access health CT
Connecticut's Health Insurance Marketplace

AH2-E00001

Short Application for Individual Health Coverage and Cost Saving Programs

Apply faster online	Apply faster online at accesshealthct.com
Use this application to see what coverage you qualify for	• Affordable private healthcare plans that offer comprehensive coverage to help you stay well. • A new tax credit that can immediately help pay a portion of your premiums for healthcare coverage. • Free or low-cost healthcare programs from Medicaid.
Who can use this application?	**Single adults who:** • Are not offered healthcare coverage from their employer. • Plan to file taxes and who will not be claimed as a tax dependent on someone else's tax return. • Do not have any dependents. **If any of the following apply you need to fill out form AH3 to make sure you get the correct coverage and benefits:** • You are married or have dependent children. • You are under age 26 and were in Connecticut foster care at age 18 or older. • You have items that can be deducted from your income. ***If your only deduction is student loan interest then you can still use this form.*** • Anyone who wants help paying for medical bills from the last 3 months. • You are an American Indian or Alaskan Native.
What you may need to apply	• Social Security number. • Immigration document numbers. • Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements) • Policy numbers for any current healthcare insurance.
What happens next?	• Send your completed and signed application to the address on page 5. • We'll follow up with you within 2 weeks by mail and you'll get instructions on the next steps to obtain health coverage. • **If you don't have all the information required, sign and submit your application anyway. If necessary, we will contact you by phone or mail to complete the application**. • If you don't hear from us and it's been 2 weeks, please call 1-855-805-4325. **Filling out this application doesn't mean you have to buy health coverage.**
Why do we ask for this information?	• We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**
Get free help with this application	• **Online:** accesshealthct.com • **Phone:** 1-855-805-4325. • **In person:** There may be counselors certified by Access Health CT in your area who can help. Visit accesshealthct.com or call 1-855-805-4325 for more information. • En Español: Llame a nuestro centro de ayuda gratis al 1-855-805-4325. • For Telecommunications Device for the Deaf (TDD or TTY) please call 1-855-789-2428 **If someone is helping you fill out this application, you will need to complete Appendix C.**

HUSKY HEALTH CONNECTICUT

AH2-E00001

Step 1 Tell us about yourself

1. Name *(first middle last suffix)*

2. **Home** address (If you do not have a Home address, please provide at least the City and State where you are seeking healthcare coverage)			3. Apartment or Suite Number
4. City	5. State	6. Zip code	7. County
8. **Mailing** address (If different from home address)			9. Apartment or Suite Number
10. City	11. State	12. ZIP code	13. County

14. Preferred phone number ☐Home ☐Work ☐ Cell

15. Other phone number ☐Home ☐Work ☐ Cell

16. Email address

17. Preferred spoken or written language (if not English)

18. Date of birth *(mm/dd/yyyy)*

19. Sex ☐ Male ☐ Female

20. Social Security Number (SSN)

__ __ __ – __ __ – __ __ __ __

We need your SSN if you want healthcare coverage and have an SSN. We use SSNs to check income and other information to see who is eligible for help with healthcare coverage costs. Providing your SSN can also be helpful since it can speed up the application process. If you or someone in your family wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

▶ *Tell us more about yourself.*

21. Are you pregnant? ☐ Yes ☐ No ***If yes***, with how many babies? _____ Due date *(mm/dd/yyyy):* _____

22. Are you a full-time high school or technical/vocational student who will graduate before turning 19 years old? ☐ Yes ☐ No

23. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No

▶ *Tell us about your citizenship.*

24. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No ***if yes,*** go to question 24.

If no, list a valid immigration document type: _____ and document ID Number: _____

☐ Check here, if you have lived in the U.S. since 1996.

☐ Check if you have had your current immigration status for 5 years or more

▶ *Tell us more about your race and ethnicity. You may choose not to answer these questions.*

25. Are you Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

26. What is your race? Check all that apply:

☐ Caucasian	☐ Asian Indian	☐ Korean	☐ Other Asian	☐ Native Hawaiian
☐ Black or African American	☐ Chinese	☐ Vietnamese	☐ Guamanian or Chamorro	☐ Other Pacific Islander
☐ American Indian or Alaska Native	☐ Filipino	☐ Japanese	☐ Samoan	☐ Other:_____

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Step 2 Tell us about your jobs and income

1. *Tell us about your work income. This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).*

Job 1: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): **$** _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

Job 2: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): **$** _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

In the past year, did you: ☐ Stop working ☐ Start working fewer hours ☐ Change jobs ☐ None of these

2. *Tell us about any self-employment income (See the "self-employment expense instructions" below)*

Self-employment 1: Type of work:

How much *net income* (income after expenses but before tax and deductions) will you typically get from self-employment?
Monthly amount: **$**_____

Self-employment 2: Type of work:

How much *net income* (income after expenses but before tax and deductions) will you typically get from self-employment?
Monthly amount: **$**_____

▶ ***Self-employment expense instructions:*** *Subtract the expenses below from gross income to get self-employment net income.*

- Car and truck expenses (not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or interruption insurance
- Interest (including mortgage interest to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

3. *Tell us about any other income. You do not need to include child support, veteran's payments or Supplemental Security Income (SSI).*

☐	Unemployment	$_____	How often? _____	☐	Retirement accounts	$_____	How often? _____
☐	Pensions	$_____	How often? _____	☐	Alimony received	$_____	How often? _____
☐	Social Security	$_____	How often? _____	☐	Net farming / fishing	$_____	How often? _____
☐	Capital gains	$_____	How often? _____	☐	Net rental or royalty	$_____	How often? _____
☐	Investments	$_____	How often? _____	☐	Other income	$_____	How often? _____
					Type: _____		

4. *Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax?*

if yes, how much? $_____ How often? _____

5. *Tell us about your yearly income.* ***NOTE****: Complete only if your income changes from month to month.*

What do you expect your yearly income (before tax and deductions) to be for the benefit/plan tax year?
Amount $_____

Step 3 Tell us about any other health coverage

Are you enrolled in any of the following (check all that apply):

☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Peace Corps
☐ Other insurance _____

If other, is this a limited benefit plan? ☐ *(like a school accident policy or dental only)*
Name of insurance company:_____
Policy number: _____

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Step 4 Read and sign this application

▶ Fast track your future renewals

*Read the statement below and check **one** box*

I give permission to Access Health CT to use information from my tax returns for the number of years I checked below. I understand that Access Health CT may be able to use this information to automatically renew my HUSKY Health (Medicaid and CHIP) without needing to send me a renewal form. I can also change my mind and not allow Access Health CT to check this information.

Yes, I give permission to check my income on tax returns for *(check one box)*:

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns

▶ Help because of a disability or impairment

Do you need a reasonable accommodation or help to complete this renewal because of a disability or impairment?

☐ Yes ☐ No

If yes, what kind do you need? _____

▶ Your rights and responsibilities

I am signing this renewal form under penalty of perjury. This means that I have been truthful in confirming the information on this form and providing corrections to and additional information for all the questions on this form. I have provided this information to the best of my knowledge. I know that I may be subject to civil and criminal penalties under state and federal law if I provide false or misleading information.

I know that I must tell Access Health CT (AHCT) or the Connecticut Department of Social Services (DSS) if anything changes or is different from what appeared on this form or if there are any changes to anything that I corrected or added to this form. I can call 1-800-805-4325 (TTY: 1-855-789-2428) or visit www.connect.ct.gov to report any changes. I understand that a change in our information might affect whether I or someone in my household qualifies for coverage.

I know that under state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file or the Connecticut Commission on Human Rights and Opportunities (CHRO) www.ct.gov/chro/site/default.asp.

By signing below, I confirm that:

- I am not incarcerated (detained or jailed).
- For the plan/benefit year I expect to file a federal income tax return, do not expect to claim any dependents on that return, and do not expect to be claimed as a dependent on anyone else's federal income tax return.
- I am not offered health coverage from an employer.

I understand that Access Health CT and the Department of Social Services need the information on this form to check our ongoing eligibility for help paying for health coverage. I understand that Access Health CT and the Department of Social Services will check our answers using information from federal data sources, including the Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, Access Health CT or the Department of Social Services may ask us to send us proof.

I understand that Access Health CT and the Department of Social Services are authorized to collect information on this form, and other supporting information, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-148, as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-152), 42 USC §§ 1320(b)-7(a)(1) and (b)(5), 42 CFR 435.920 and Conn. Gen. Stat. § 17b-77.

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Step 4 Read and sign this application (continued)

▶ **If anyone on this application is eligible or found eligible for HUSKY Health (Medicaid or CHIP)**

I am giving to the Department of Social Services (the Medicaid agency) the rights to pursue and get medical support from a spouse or parent.
List the names of any children in the household who have a parent living outside the home:

_____

I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating with the agency that collects of medical support will harm me or my children, I can tell the Department of Social Services and I may not have to cooperate.

I give permission to Access Health CT and the Department of Social Services to release information about me and others in my household who are receiving benefits for purposes directly connected with the administration of the HUSKY Health Program. Purposes directly connected with the administration of the program include, but are not limited to, establishing eligibility, determining the amount of assistance, providing services, and the investigation, prosecution, or civil proceedings related to the administration of the HUSKY Health program.

I understand that all information on this form, including Social Security numbers, is confidential, except as permitted or required by court order, state or federal law. I understand that if the Department of Social Services believes that there is imminent danger to a child's or family's health, safety or welfare, they will provide the child's address and telephone number to the Department of Children and Families.

I understand that after my death, the Department of Social Services can file a claim against my estate to recover money that the agency paid for coverage provided to me. If I am qualified for HUSKY A and 55 years or older, the state can recover for all types of medical care. If I am qualified for HUSKY D and 55 years or older, the state can recover only for my nursing facility services, home and community based services or related hospital and prescription drug services. The amount recovered will not be more than the amount the HUSKY Health paid for my care. The State may bill my legally liable relative to repay it for the costs of my medical care.

I understand that information on this form is subject to verification by federal and state officials. I will cooperate with these officials by providing authorizations, documents, and other proof to prove what I have said. I will cooperate with state and federal personnel in Quality Control Reviews.

I understand that money from a pending or future lawsuit will go (be assigned) to the State of Connecticut to recovery any medical expenses paid by HUSKY Health related to the lawsuit. By receiving medical assistance, I allow the State to recover the cost of my medical bills that are covered by a third party, such as other insurance, directly from that third party.

By applying for medical assistance, I give (assign) my right of support from third parties to the Department of Social Services.

▶ **Your right to appeal**

If I think Access Health CT or the Department of Social Services has made a mistake on my eligibility, I can appeal the decision. I may ask for a hearing, in writing, by telephone, or by email if I disagree with an action taken. I can find out how to appeal by contacting Access Health CT at 1-855-805-4325.

▶ *Sign this application. The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix C.*

Signature of household contact or authorized representative: **Date *(mm/dd/yyyy):***

Step 5 Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

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Appendix C

Assistance with completing this application

► *You can choose an authorized representative to assist in completing the application (certified application counselors, in-person assisters, navigators and brokers please see below).*

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Access Health CT at 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

► *If you have an authorized representative now, or would like to add one, please answer these questions.*

Select the type of representative:

☐ Court Appointed Representative and Power of Attorney

☐ Responsible Adult

1. Name of authorized representative *(first middle last suffix)*:		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Email		
9. Would you like to receive copies of notifications? ☐ Yes ☐ No ***if yes***, preferred language: _____		
10. Organization name		11. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
12.Your signature		13. Date *(mm/dd/yyyy)*

For certified application assisters, counselors, navigators, and brokers only.

► *Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.*

1. Application start date *(mm/dd/yyyy)*	
2. Name *(first middle last suffix)*	
3. Organization name	4. ID number (if applicable)